SERFF Tracking Number:	*APLE-127188398*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*48941*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplement to Application - IA9917*		
Project Name/Number:	*/*		

Filing at a Glance

Company: IA American Life Insurance Company

Product Name: Supplement to Application - IA9917	SERFF Tr Num: APLE-127188398	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 48941
Sub-TOI: L08.000 Life - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Traci Baty	Disposition Date: 06/08/2011
	Date Submitted: 05/31/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Traci Baty
Filing Description:
Cover Letter under Supporting Documentation.

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Filed in Georgia, our State of Domicile.
Market Type: Individual
Individual Market Type:
Filing Status Changed: 06/08/2011
State Status Changed: 06/08/2011
Created By: Traci Baty
Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Clara Keel, Product Filing Manager
425 Austin Ave
Waco, TX 76701

ckeel@aatx.com
254-297-2794 [Phone]

SERFF Tracking Number:	*APLE-127188398*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*48941*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplement to Application - IA9917*		
Project Name/Number:	*/*		

Filing Company Information

IA American Life Insurance Company	CoCode: 91693	State of Domicile: Georgia
17550 N. Perimeter Dr.	Group Code: 315	Company Type: LAH
Suite 210	Group Name: Industrial Alliance Group	State ID Number:
Scottsdale, AZ 85255-0131	FEIN Number: 13-3036472	
(480) 473-5540 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
IA American Life Insurance Company	$50.00	05/31/2011	48199589

SERFF Tracking Number:	*APLE-127188398*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*48941*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplement to Application - IA9917*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/08/2011	06/08/2011

SERFF Tracking Number:	*APLE-127188398*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*48941*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplement to Application - IA9917*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 06/08/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*APLE-127188398*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*48941*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplement to Application - IA9917*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Cover Letter		Yes
Form	Supplement to Application		Yes

SERFF Tracking Number:	*APLE-127188398*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*48941*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplement to Application - IA9917*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form No. IA9917	Other	Supplement to Application	Initial		51.500	IA9917.pdf

IA AMERICAN LIFE INSURANCE COMPANY

P.O. Box 2549, Waco, TX 76702-2549

SUPPLEMENT TO APPLICATION

(Application Supplement in Continuation of and Forming a Part of my Application for Insurance)

Proposed Insured Name (Print): _____

PART III – HEALTH QUESTIONS

"Treated" or "Treatment" as used in the health questions that follow is defined as the diagnosis, the prescribing of any medication or course of action, undergoing or being advised to undergo any diagnostic testing or any stay in a health care facility".

1. Have you smoked cigarettes in the past 24 months? ..... ☐ YES ☐ NO
2. In the past 12 months, have you taken 3 or more medications at the same time to control high blood pressure? ..... ☐ YES ☐ NO
3. Have you ever been Treated, advised to receive Treatment, including maintenance medications, for cancer (other than basal cell carcinoma), malignant melanoma or leukemia?... ☐ YES ☐ NO
4. In the past 3 years, have you been Treated or advised to recieve Treatment for major depression, schizophrenia, or bi-polar disorder? ..... ☐ YES ☐ NO
5. In the past 10 years, have you been Treated or advised to receive Treatment (including maintenance medications) for heart attack, heart disease or disorder, angina, stroke, diabetes, congestive heart failure, transient ischemic attack (TIA) or seizures? ..... ☐ YES ☐ NO
6. In the past 10 years, have you been Treated or advised to receive Treatment (including maintenance medications) for liver disease, kidney disease or kidney failure, or Chronic Obstructive Pulmonary Disease (COPD)? ..... ☐ YES ☐ NO
7. List Current Prescription Medications:_____

_____

_____

I hereby agree that this supplement shall be an amendment to and form a part of my application for insurance, and be a part of any contract of insurance issued on the basis of such application.

Signed at _____ Application Date _____

CITY STATE MONTH DAY YEAR

_____ _____

SIGNATURE OF PROPOSED INSURED SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

_____

WITNESS-LICENSED AGENT SIGNATURE

SERFF Tracking Number:	*APLE-127188398*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*48941*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplement to Application - IA9917*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR IA9917 Readability Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Application GL213AR, approved by your department on January 24, 2011

Attachment:

Gl213AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Cover Letter

Comments:

Cover Letter attached.

Attachment:

AR IA9917 Cover Letter.pdf

ARKANSAS

IA AMERICAN LIFE INSURANCE COMPANY

CERTIFICATION

This is to certify that the attached Supplement to Application, Form Number IA9917, has achieved a Flesch Reading Ease Score of 51.5 and complies with the requirements of Arkansas Statue 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Simplification Act.

Signature

Clara Keel, FLMI
Product Filing Manager and Assistant Secretary
American-Amicable Life Insurance Company of Texas
A subsidiary of IA American Life Insurance Company

May 25, 2011

IA AMERICAN™ LIFE INSURANCE COMPANY

www.iaamerican.com

IA AMERICAN LIFE INSURANCE COMPANY
P.O. BOX 2549, WACO, TX 76702-2549
800-736-7311

FINAL EXPENSE
LIFE INSURANCE APPLICATION
(Please print in black ink)

Telephone Case No:_____

Proposed Insured _____ (First) (Middle) (Last)

Address (No. & Street)_____

City State Zip Code

Telephone interview completed ☐ Yes ☐ No

_____ _____ ☐ am ☐ pm
Phone Best time to call

E-mail Address

☐ Male ☐ Female	Date of Birth / /	Age	State of Birth	Social Security Number / /	Height ft in	Weight lbs

Owner: Name_____Relationship_____SS#_____/____/_____
Address City/State/Zip

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

Plan: ☐ Immediate Death Benefit ☐ Graded Death Benefit (Percentage of Face Amount)
During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? ☐ Yes ☐ No
Face Amount of Insurance $

Rider: ☐ Grandchild/Great Grandchild Coverage (Indicate Number of Children Applying) _____
☐ Child Rider_____ Units ☐ ADB Amt $

Automatic Premium Loan Elected? ☐ Yes ☐ No

Mode: ☐ Bank Draft ☐ Draft 1st Prem on Req. Date ☐ Other Modal Prem $

CWA: ☐ E-Check Immediate 1st Prem ☐ Collected $

Mail Policy To: ☐ Agent ☐ Insured ☐ Owner
Requested Policy Date: / /

A. Do you have existing life insurance or an annuity contract? ☐ Yes ☐ No
B. Will you replace an existing life insurance policy or an annuity? ☐ Yes ☐ No

Company
Policy # Amount of Coverage $

Physician Name: City/State: Phone:

HEALTH INFORMATION

1. Are you currently hospitalized, confined to a bed or nursing facility, confined to a wheelchair due to chronic illness or disease, or using oxygen equipment to assist in breathing, or receiving Hospice Care? ☐ Yes ☐ No
2. Have you had or been medically advised to have an organ transplant, or have you been medically diagnosed as having metastatic cancer, Alzheimer's, dementia, mental incapacity, or have you been diagnosed, treated (including dialysis) or taken medication for renal insufficiency, kidney failure, liver failure, or respiratory failure? ☐ Yes ☐ No
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
4. Have you been medically diagnosed with diabetes combined with a medical history of any of the following: stroke, TIA, heart disease, heart attack, coronary artery bypass, angioplasty, circulatory disease, or peripheral vascular disease? ☐ Yes ☐ No
5. Have you taken insulin shots prior to age 50 or been treated for insulin shock or diabetic coma? ☐ Yes ☐ No
6. Have you ever been medically diagnosed, treated, or taken medication for congestive heart failure, cardiomyopathy, Lou Gehrig's disease, Huntington's disease, had an amputation caused by disease, or more than one occurrence of cancer (excluding basal or squamous cell skin cancer) in your lifetime? ☐ Yes ☐ No
7. Within the past 12 months have you:
   a. been medically diagnosed or treated for angina (chest pain), stroke or TIA, cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? ☐ Yes ☐ No
   b. had a heart attack, aneurysm, heart valve surgery, coronary artery bypass surgery, angioplasty, or stent implant or had or been medically advised to have surgery for brain or heart disorders (including, but not limited to catheterization, a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? ☐ Yes ☐ No
   c. been medically diagnosed, treated, or taken medication for internal cancer, lymphoma, melanoma, leukemia, or systemic lupus (SLE)? ☐ Yes ☐ No
   d. had any diagnostic testing, surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? ☐ Yes ☐ No
   e. used illegal drugs or abused alcohol or drugs, or had or been recommended to have treatment or counseling for alcohol or drug use, or been convicted of any felony or driving under the influence of alcohol or drugs? ☐ Yes ☐ No

If any answer to questions 1 through 7 is answered "Yes" the Proposed Insured is not eligible for any coverage.

8. Within the past 24 months have you been medically diagnosed or treated, or hospitalized for:
   a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ☐ Yes ☐ No
   b. or taken medication for internal cancer, leukemia, melanoma, emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, liver disease? ☐ Yes ☐ No
   c. paralysis of two or more extremeties or any neuro-muscular disease (including, but not limited to cerebral palsy, multiple sclerosis, seizures, or Parkinson's disease)? ☐ Yes ☐ No

If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.

If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.

GL213AR

NOTICE
Printed in compliance with Public Law 91-508

Thank you for considering IA America Life Insurance Company for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. IA American Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

IA American Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

CHILD, GRANDCHILD, AND GREAT GRANDCHILD COVERAGE - Children Proposed for Insurance (list additional children on a separate sheet):

Proposed Insured Name	Sex	Birthdate	Relationship	Proposed Insured Name	Sex	Birthdate	Relationship

PROPOSED CHILDREN'S HEALTH STATEMENT—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months. List the names of children that are exceptions to PROPOSED CHILDREN'S HEALTH STATEMENT. *Children listed as an exception are excluded from the appropriate Child Rider Coverage.* Exceptions are:_____

AGREEMENT—I agree with IA American Life Insurance Company (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the MIB, Inc. or other organization that has knowledge or records of me and my health to give such information to: (a) IA American Life Insurance Company; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the MIB, Inc., are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize IA American Life Insurance Company to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the MIB, Inc.; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, the MIB Pre-Notice, the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

Signed at _____ Date of Application _____
CITY STATE MONTH DAY YEAR

_____ _____
SIGNATURE OF PROPOSED INSURED SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

AGENT'S REPORT

Does the proposed insured have any existing life insurance or annuity contract? ..... ☐ Yes ☐ No
Is the proposed insurance intended to replace or change any existing life insurance or annuity? ..... ☐ Yes ☐ No

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature.

I certify that the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms have been presented to the applicant, if applicable. AGENT'S REMARKS:_____

_____ _____ _____ _____
AGENT'S PRINTED NAME DATE AGENT'S PRINTED NAME DATE

Agent _____ No: _____ % _____ Agent _____ No: _____ % _____
SIGNATURE SIGNATURE

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured_____ Account Holder_____
Financial Institution_____ Address_____
Transit/ABA Number_____ Account Number_____ ☐ Checking ☐ Savings Requested Draft Day (1st-28th)_____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of IA American Life Insurance Company, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ _____
SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS) DATE

GL213AR

IA AMERICAN LIFE INSURANCE COMPANY
P.O. BOX 2549, WACO, TX 76702-2549

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

Received of_____ the sum of $_____ as first payment on this application.

Date_____ Agent_____

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED $30,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met, the liability of the Company shall be limited to the return of any amount paid.

IA AMERICAN™
LIFE INSURANCE COMPANY

P.O. Box 2549 / Waco, Texas 76702-2549
254-297-2774

May 31, 2011

NAIC No. 91693

Mr. Joe Musgrove
Policy and Other Form Filings
State of Arkansas
Department of Insurance
1200 West Third Street
Little Rock, Arkansas 72201-1904
Attention: Compliance - Life and Health

Re: Form No. IA9917 – Supplement to Application

Dear Mr. Musgrove:

The above referenced Supplement to Application is being submitted for your consideration and approval. This application supplement is new and will not replace any application approved by your department.

Supplement to Application, Form No. IA9917, will be used as a supplement to Application GL213AR, approved by your department on January 24, 2011. This Supplement to Application will be used to apply for a preferred plan of whole life insurance. The Flesch readability score for the supplemental application combined with the application is 51.5.

The above referenced submission meets the provisions of Arkansas Rule and Regulation 19 (Unfair Sex Discrimination in the Sale of Insurance) as well as all applicable requirements of the department.

If I may be of assistance in your review, please contact me at 1-800-736-7311, extension 3216, or ckeel@aatx.com.

Sincerely,

Clara Keel

Clara Keel, FLMI
Product Filing Manager & Assistant Secretary
American-Amicable Life Insurance Company of Texas
A subsidiary of IA American Life Insurance Company